

# BTL VANQUISH ME™

## PATIENT RECORD

Patient's name:	Date of birth:	Age:
Phone#	Email:	

**Relevant Medical History:**

1. Do you have or have you had a hernia?  YES\*  NO \*If YES Please list: \_\_\_\_\_
2. Are you currently taking prescription, herbal, or over the counter medication?  YES\*  NO \*If YES Please explain: \_\_\_\_\_
3. List all past and current medical conditions. \_\_\_\_\_  
\_\_\_\_\_
4. Have you had any surgeries?  YES\*  NO \*If YES Please list: \_\_\_\_\_  
\_\_\_\_\_
5. **Do you have any metal in your body** including active implants such as a pacemaker, cardiac defibrillator, cochlear implant or non-active implants such as screws, stents, hip replacement, knee replacement?  YES\*  NO \*If YES Please list and explain: \_\_\_\_\_
6. Are you currently pregnant or nursing?  YES\*  NO
7. If you are a woman of childbearing potential are you using birth control?  YES\*  NO\* \*Please explain: \_\_\_\_\_  
\_\_\_\_\_
8. Do you have a history of any skin disease or sensitivity? \*If YES Please explain: \_\_\_\_\_
9. What is your daily intake of water (cups)?  0-2  2-4  4-6  6-8  more
10. Do you engage in any light physical activity such as walking? Check which best applies:  
 Never  Rarely  Sometimes  Always
11. Do any of the discussed contraindications apply to you?  YES\*  NO \*If YES Please explain: \_\_\_\_\_
12. Which area(s) are you interested in receiving BTL Vanquish ME treatments? Please list and mark the areas on the diagram.  
\_\_\_\_\_

# BTL VANQUISH+ ME™

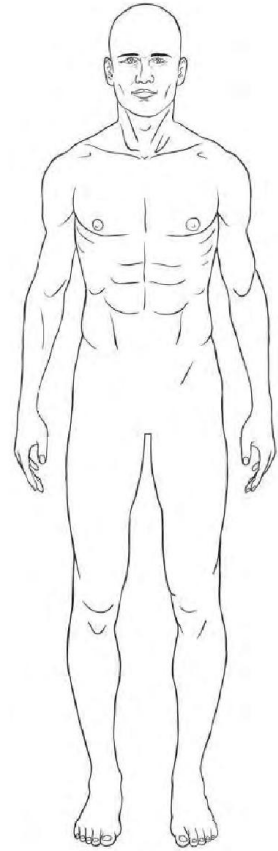
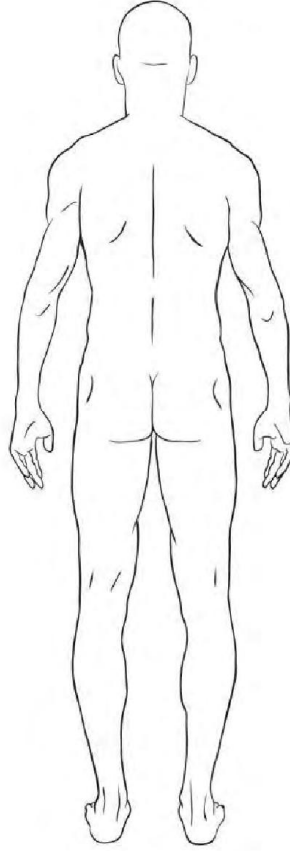
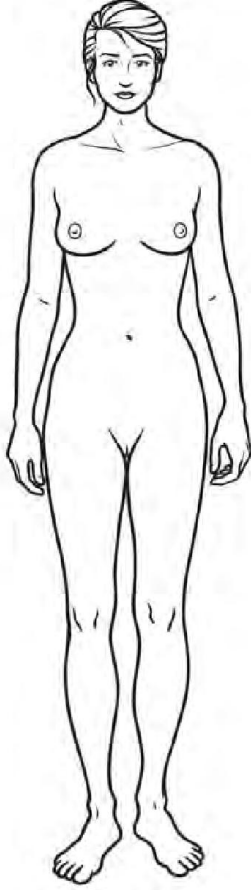
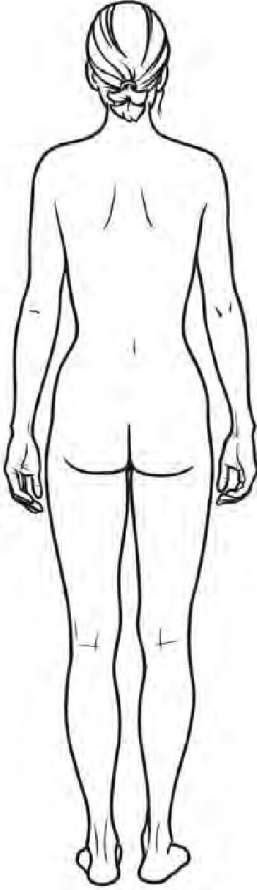
## PATIENT RECORD

### Relevant Medical History:

Mark area(s) on diagram:

N/A

N/A



Patient signature below indicates that the above information is accurate and current.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Baseline Measurements:** Date \_\_\_\_\_ Weight: \_\_\_\_\_ Lbs Circumference: \_\_\_\_\_ CM